(15) (16) (16)

Nos. 93-1408, 93-1414 and 93-1415

IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*,
Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, *et al.*,
Respondents.

MARIO M. CUOMO, *et al.*,
Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, *et al.*,
Respondents.

HOSPITAL ASSOCIATION OF NEW YORK STATE,
Petitioner,

vs.

THE TRAVELERS INSURANCE COMPANY, *et al.*,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR RESPONDENTS THE TRAVELERS INSURANCE COMPANY, *ET AL.*

STEPHEN M. SHAPIRO
KENNETH S. GELLER
ANDREW J. PINCUS
CHARLES ROTHFELD
DONALD M. FALK
MAYER, BROWN & PLATT
2000 Pennsylvania Ave., N.W.
Washington, D.C. 20006
(202) 463-2000

CRAIG P. MURPHY*
DARRELL M. JOSEPH
DANIEL W. DIENST
WINDELS, MARX, DAVIES & IVES
156 West 56th Street
New York, New York 10019
(212) 237-1000

* *Counsel of Record*

(For Further Appearances See Reverse Side of Cover)

64 pp

JAMES M. MICHENER
The Travelers Insurance Company
Hartford, Connecticut 06183

SETH A. JACOBS
The Travelers Health Network of New York, Inc.
Richardson, Texas, 75082

JANE MEYER
Mutual of Omaha Insurance Company
Omaha, Nebraska 68175

SUECAROL BUCKNER
The Union Labor Life Insurance Company
Washington, D.C. 20001

ZOË BAIRD
Aetna Life Insurance Company
Aetna Health Plans of New York, Inc.
Hartford, Connecticut 06156

THERESA L. SOROTA
The Health Insurance Association of America
Washington, D.C. 20036

PHILLIP E. STANO
American Council of Life Insurance
Washington, D.C. 20004

RAYMOND A. d'AMICO
Life Insurance Council of New York, Inc.
Albany, New York 12210

PAUL JOHNSTON
Professional Insurance Agents of New York, Inc. Trust
Glenmont, New York 12077

QUESTION PRESENTED

Whether Section 514(a) of the Employee Retirement Income Security Act of 1974 preempts New York laws that impose substantial surcharges on the hospital costs incurred by employee benefit plans in an effort to induce such plans to select a particular type of health care coverage.

RULE 29.1 STATEMENT

This brief is submitted on behalf of the following respondents, whose parent companies and subsidiaries (except wholly owned subsidiaries) are indicated below, pursuant to Supreme Court Rule 29.1.

1. **The Travelers Insurance Company**

   Parents: The Travelers Inc. (formerly Primerica Corporation, successor to The Travelers Corporation); Associated Madison Companies, Inc.; and The Travelers Insurance Group Inc.

   Subsidiaries: Applied Expert Systems, Inc.; and Primerica Financial Services Ltd.

2. **The Travelers Health Network of New York, Inc.**

   Parents: The Travelers Inc.; Associated Madison Companies, Inc.; The Travelers Insurance Group Inc.; The Travelers Insurance Company; The Travelers Employee Benefits Company Inc.; The Travelers Health Company; and The Travelers Health Network, Inc.

3. **Health Insurance Association of America**

   None.

4. **American Council of Life Insurance**

   None.

5. **Life Insurance Council of New York, Inc.**

   None.

6. **Aetna Life Insurance Company**

   Parent: Aetna Life and Casualty Company.

   Subsidiaries: Aetna Health Plans of Florida, Inc.; Partners Health Plan of Pennsylvania, Inc.; Aetna Series Fund, Inc.; Med Southwest, Inc.; PHPSNE Parent Corporation; and Smith Whiley & Company.

7. **Aetna Health Plans of New York, Inc.**

   Parents: Aetna Life and Casualty Company; Aetna Life Insurance Company; AHP Holdings, Inc.; and HEALTHWAYS Systems, Inc.

8. **Mutual of Omaha Insurance Company**

   Subsidiary: Preferred HealthAlliance, Inc.

9. **The Union Labor Life Insurance Company**

   Parent: Ullico Inc.

10. **Professional Insurance Agents of New York, Inc. Trust**

    None.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES: **Page**

CASES: **Page**

STATUTES:

STATUTES: **Page**

STATUTES: **Page**

CONGRESSIONAL MATERIALS:

OTHER MATERIALS:

OTHER MATERIALS: **Page**

STATEMENT OF THE CASE

The State of New York has enacted statutes imposing substantial surcharges on the hospital costs incurred by patients covered by any form of health plan other than Blue Cross/Blue Shield (the Blues) or governmental insurance such as Medicaid. These surcharges, as the State has acknowledged, were expressly designed to "increase hospital costs for patients covered by health plans other than the Blues" (J.A. 52) and thereby to assist the Blues "in their competition with commercial insurers" (J.A. 165-66). Following numerous decisions of this Court, both courts below held that the state laws were preempted by Section 514(a) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1144(a), because they "purposely interfere with the choices that ERISA plans make for health care coverage" and "substantially increase the cost to ERISA plans of providing beneficiaries with a given level of health care benefits," which in turn would "lead plans to reduce their level of service or benefits." Pet. App. A22, A23.[1]

A. The New York Surcharge Statutes.

1. Most Americans (excluding those qualifying for programs like Medicare and Medicaid) receive their health care coverage through employee welfare benefit plans subject to ERISA. According to an independent study published in 1992, of the 158.3 million non-elderly Americans who have private health insurance, 138.7 million – roughly 88% – receive such coverage through their employers. J.A. 125. None of the petitioners challenged this fact in the courts below. Indeed, they concede in this Court that "ERISA plans are a major source of private health care coverage" (N.Y. Br. 10), and that "[i]t is undisputed that members of ERISA plans are significant consumers of hospital services" (HANYS Br. 24 n.19).

---

[1] "Pet. App." refers to the appendix to the petition in No. 93-1414.

See also U.S. Bureau of the Census, STATISTICAL ABSTRACT OF THE UNITED STATES 118 (114th ed. 1994); U.S. Br. 4.

Employers and other plan sponsors that establish ERISA welfare plans must choose among a number of alternatives in providing health and hospital coverage to their employees. Many ERISA plans enter into health insurance contracts with a commercial insurer, which reimburses certain health care costs incurred by plan participants in return for a premium calculated to cover the costs of paying the claims and administering the policy. Other ERISA plans engage in self-insurance, whereby the plan itself is directly responsible for medical and hospital bills. Yet other ERISA plans choose to subscribe to an HMO, which is paid a predetermined rate in return for providing health care services to plan participants. Finally, some ERISA plans obtain coverage through non-profit health service corporations such as Blue Cross/Blue Shield. J.A. 35-36, 123-24.

2. Like a few other states,[2] New York regulates the rates at which hospitals are reimbursed for the costs of inpatient care. As a general rule, the rates for inpatient hospital care are determined on the basis of categories, known as "Diagnosis Related Groups" or "DRGs," that depend upon the diagnosis of a patient's illness rather than the actual cost of treatment. Pursuant to this system, hospitals charge patients the rate applicable to their assigned DRG, subject to certain adjustments reflecting costs specific to that hospital. Pet. App. A7; J.A. 152. Respondents have never challenged this even-handed aspect of New York's Prospective Hospital Reimbursement Methodology (NYPHRM), which has been in effect for more than a decade.

---

[2] The brief filed by the National Governors' Association, *et al.*, as *Amici Curiae* (NGA Br. 18 n.11) identifies three states in addition to New York -- Maine, Maryland and West Virginia -- that have mandatory hospital rate-setting laws.

Unique among the states, however, New York provides that the amount charged to a patient is then increased by a "payor factor," depending solely upon the type of health care coverage protecting the patient. New York Public Health Law Section 2807-c(1)(b), enacted in 1988, requires that the DRG rate for inpatient services be increased by a 13% surcharge when the patient is covered by any form of health plan (including self-insurance) other than the Blues, an HMO, or government plans such as Medicare. The funds generated by the 13% surcharge are retained by the hospitals. Pet. App. A7.

In addition, New York's Omnibus Revenue Act of 1992 (Omnibus Act) imposed two more surcharges. First, Section 348 of the Omnibus Act amended Section 2807-c(11)(i) of New York's Public Health Law to impose an 11% surcharge on DRG payment rates charged by hospitals to patients covered by commercial insurance. Consequently, the total surcharge for commercially insured patients -- and thus the differential between the Blues' and commercial insurers' charges -- was set at 24%. In contrast with the funds generated by the 13% surcharge, the proceeds of the 11% surcharge ultimately are paid into the State treasury. Pet. App. A8.

Second, Section 346 of the Omnibus Act (codified at N.Y. Pub. Health Law § 2807-c(2-a)(a)) created a new surcharge of up to 9% on the cost of inpatient hospitalization paid by HMOs. This surcharge may be reduced or eliminated for HMOs that enroll a specified number of Medicaid patients. Like the 11% surcharge, the 9% surcharge ultimately is deposited into the State's general fund. Pet. App. A8.[3]

---

[3] Current New York law retains the 13% surcharge. The 11% surcharge applied only to patients discharged between April 1, 1992, and March 31, 1993, and is no longer in force. The life of the 9% surcharge has been extended to December 31, 1995. See 1995 N.Y. Laws, ch. 731, § 35.

B. The Proceedings In This Case.

1. *Respondents' Lawsuit.* In the summer of 1992, respondents brought suit in the United States District Court for the Southern District of New York, seeking to enjoin the State from enforcing the surcharges against any commercial insurers, self-insurers or HMOs in connection with their coverage of any ERISA welfare benefit plans. Respondents contended that the state laws are preempted by Section 514(a) of ERISA, 29 U.S.C. § 1144(a), because they "relate to" employee benefit plans and are not saved as a regulation of insurance.[4] Petitioners New York State Conference of Blue Cross and Blue Shield Plans, Empire Blue Cross and Blue Shield, and Hospital Association of New York State intervened as defendants, and respondents New York State Health Maintenance Organization Conference and certain individual HMOs intervened as plaintiffs.

Respondents demonstrated in the district court that New York's surcharges substantially increased the costs to ERISA plans of providing benefits through commercial insurance, self-insurance, or HMOs. Because self-insured plans undertake to pay for covered medical services provided to their participants, they must pay the 13% surcharge directly. Similarly, commercial insurance policies often provide that the premiums charged will depend upon the amount of benefits paid. In that situation, the plans bear the burden of the 13% and 11% surcharges. More generally, the premiums charged for insurance, or the rates charged by HMOs, must be set at a level that will recapture the costs of providing benefits. State

---

[4] Certain respondents also challenged the 13% and 11% surcharges on the ground that they are preempted by the Federal Employee Health Benefits Act, 5 U.S.C. § 8909(f)(1) (Supp. IV 1992). Also challenged on ERISA preemption grounds was a circular issued by the New York State Insurance Department entitled "Actuarial Information Letter No. 5." The court of appeals agreed with those contentions (Pet. App. A12-A17, A30-A34), which are not at issue in this Court.

laws increasing those costs -- here, the 13%, 11% and 9% surcharges -- directly increase the amounts that ERISA plans must pay to provide a given level of benefits. J.A. 133-34; 137; 140; 145.

For example, respondent Travelers Insurance Company introduced the following uncontradicted evidence. First, the 11% surcharge caused ERISA plans in New York to experience premium increases of from 2% to 5%. J.A. 299. Second, the 13% surcharge represented approximately 2% to 5% of the premiums paid by ERISA plans for group accident and health insurance. J.A. 300. Travelers also estimated that in the case of the Sheridan Catheter Plan (a self-insured fund for which Travelers provides claims administration services), the 13% surcharge would cost the plan approximately 2.4% of its health benefit costs for 1992. *Ibid.* Finally, Travelers estimated that for the period April 1, 1992 through April 1, 1993, the 13% surcharge would result in millions of dollars of added costs to the 91 self-insured ERISA plans for which it provides claims administration services, and that the 13% and 11% surcharges would result in added costs of many millions more to the ERISA plans covered by its commercial insurance policies. *Ibid.* Other commercial insurers and HMOs offered virtually identical experiences. See, *e.g.*, J.A. 133-34, 137-38, 140, 145.

Thus, the evidence adduced in the district court clearly demonstrated the practical impact of the New York statutes: an ERISA plan sponsor that chooses to provide medical benefits through commercial insurance, self-insurance or an HMO either must pay higher costs reflecting the surcharges to offer the same level of benefits or must reduce benefits to offset these additional costs. Moreover, these additional costs inevitably divert plan resources from the provision of health care benefits to plan participants, in order to subsidize the general revenue needs of the State of New York (in the case of the 11% and 9% surcharges) or hospitals' general revenue needs (in the case of the 13% surcharge). The impact of these

surcharges is enormous, costing plan sponsors or plan participants hundreds of millions of dollars annually. J.A. 303, 310, 327. The "obvious effect," as the court of appeals explained, "is to increase commercial insurers' costs of providing health care, thus making them less competitive with the Blues." Pet. App. A8.

The evidence also demonstrated, not surprisingly, that New York adopted the surcharges for the very purpose of influencing the decision-making of plan sponsors. For example, New York's Deputy Superintendent of Insurance testified that the 13% surcharge was intended to provide a " 'level playing field' " to the Blues "in their competition with commercial insurers" in order to offset a perceived "competitive disadvantage of these not-for-profit corporations and an inability to maintain a mix of high, low and average risks." J.A. 165-66. See also J.A. 237 (quoting Governor Cuomo as stating that the surcharges were designed to provide "competitive support for Blue Cross"); J.A. 327, 334 (same). As the Blues candidly conceded in the district court, the surcharges were designed to permit them "to remain competitive" (J.A. 292), "to level the competitive marketplace" (J.A. 217), and to make purchasers of health insurance "think twice as hard" before choosing a commercial insurer. J.A. 207, 217-18, 232. Thus, it is undisputed that the statutes were enacted to drive the purchasers of health care coverage in New York (which overwhelmingly are ERISA plans) to the Blues in order to help them resolve their serious financial problems.[5]

---

[5] Petitioners suggest (see N.Y. Br. 5; Blues Br. 9) that the Blues' financial crisis was attributable to competitive advantages by commercial insurers and a deterioration in the community-rated pools. In fact, the heart of Empire's deep financial crisis was not cherry-picking by HMOs and private insurers but rather the "gross mismanagement" of the company's own top executives, characterized by "wasteful expenditures, fraud, and a history of inattentiveness and non-action * * *." See *Oversight of the Insurance Industry: Blue Cross/Blue Shield -- Empire Plan (New York):*

(Footnote continued)

2. *The District Court's Decision.* The district court granted summary judgment for respondents, holding that the surcharges were preempted to the extent they applied to ERISA plans. Judge Freeh found that the surcharges fell within Section 514(a) of ERISA because they unquestionably "relate to" ERISA plans. First, the surcharges have a significant effect on insurers and HMOs providing coverage to ERISA plans and therefore lead to a substantial increase in plan costs. Pet. App. A71. Second, and "[m]ore importantly," the State's and the Blues' "entire justification for the [s]urcharges is premised on that exact result -- that the [s]urcharges will increase the cost of obtaining medical insurance through any source other than the Blues to a sufficient extent

---

Hearings Before the Permanent Subcommittee on Invetigations of the Senate Committee on Governmental Affairs, 103d Cong., 1st Sess. 5 (1993). Significantly, the Subcommittee's staff found that the New York State Insurance Department, by blaming Empire's financial woes on "unfair competition" from profit-making insurers, had wholly abdicated its oversight responsibilities. *Id.* at 6, 143, 203-11. The Subcommittee also noted the allegations that Empire "used false data in order to convince the New York Legislature to pass landmark legislation in 1992." *Id.* at 2.

Petitioners also suggest (see N.Y. Br. 3; HANYS Br. 6) that the surcharges are justified as a reward for the Blues' "unique" community-rating and open-enrollment practices. But New York recently reenacted the 13% surcharge even though, effective April 1, 1993, New York now requires *all* insurers to adopt these practices in their underwriting of individual and small group plans. See N.Y. Ins. Law § 3231; N.Y. Br. 5; Blues Br. 9-10 n.8. Moreover, in the mid- and large-group markets, the Blues behave exactly like commercial insurers, offering experience-rated programs and self-insured claims administration services. J.A. 268, 275. The Blues' insured business nonetheless benefits in those markets from the competitive advantage of the 13% surcharge.

In response to the Blue's one-sided discussion of the "legislative history" of the differential (Blues Br. 10-13), we note that the state government body convened to review it concluded that its supposed social policy justifications were "subjective, conjectural and uncertain" (J.A. 279), and recommended that it be "phased out" in the absence of any "direct and quantifiable link * * * between the differential and appropriate social goals" (J.A. 283-84).

that customers will switch their coverage to and ensure the economic viability of the Blues." *Id.* at A72 (footnote omitted). Third, the surcharges "may [a]ffect the structure and/or administration of such plans." *Id.* at A73. Since commercial insurers and HMOs pass their increased costs on to covered plans, such plans "may reduce the level of benefits or services offered rather than increase costs to participants -- a burden on plan administration which ERISA was designed to avoid." *Id.* at A74. Finally, if covered plans chose to offset increased costs of benefits by changing benefit levels, the "[s]urcharges will, at least indirectly, impose inconsistent obligations upon multi-state plans -- exactly the type of burden ERISA's preemption clause was intended to prevent." *Ibid.*

Judge Freeh also concluded that none of the surcharges was "saved" from preemption as a regulation of insurance. He explained that the surcharges do not "relate directly to the policy relationship between the insurer and the insured" and are "not limited to the insurance industry." *Id.* at A81. In addition, "as defendants themselves appear to concede, the [s]urcharges' primary goal is to regulate hospital rates, not commercial insurers." *Id.* at A80.

3. *The Court of Appeals' Decision.* The Second Circuit unanimously affirmed. It agreed with the district court that the challenged surcharges "relate to" covered plans, and therefore are preempted by ERISA, because they

> are designed to increase hospital costs for patients covered by health plans other than the Blues, and thus make these competing plans less attractive than the Blues. Obviously the surcharges will affect ERISA plans' health care benefits. Likewise, the 9% assessment imposed on HMOs will interfere with a plan's selection of the most effective method to provide benefits. *Thus, the surcharges purposely interfere with the choices that ERISA plans make for health care coverage.* Such interference is sufficient to constitute "connection with" ERISA plans.

Id. at A22 (emphasis added).

The court of appeals further found the requisite "relation to" ERISA plans by noting that the surcharges "substantially increase the cost to ERISA plans of providing beneficiaries with a given level of health care benefits" and thus "force ERISA plans either to increase plan costs or reduce plan benefits." Pet. App. A23. Therefore, the surcharges "have an impermissible impact on ERISA plan structure and administration." *Id.* at A24.

The court of appeals also agreed with Judge Freeh that the surcharges are not "salvaged by ERISA's savings clause as a law that regulates insurance." *Id.* at A25. To begin with, the Second Circuit found that the surcharges are not insurance regulations as a matter of common sense: "they aim to regulate hospital rates" and "do not address matters typically within the purview of state insurance regulations" (*id.* at A27). Furthermore, the surcharges met only one of the three criteria that this Court has identified as relevant in determining whether an otherwise preempted law "regulates insurance" within the meaning of the McCarran-Ferguson Act. They "do not regulate any practice that is integral to the insurer-insured relationship" and "are not 'limited to entities within the insurance industry.' " *Id.* at A28-A29 (quoting *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 49 (1987)).

INTRODUCTION AND SUMMARY OF ARGUMENT

ERISA's preemption provisions have been a frequent subject of this Court's opinions. The "preemption clause" found in Section 514(a) of the statute -- which this Court repeatedly has described as remarkably broad -- preempts state laws that "relate to any employee benefit plan." Section 514(b) then creates several "narrow exceptions" to this rule of preemption (120 Cong. Rec. 29,197 (1974) (remarks of Rep.

Dent)), including one (the "savings clause") for state laws that "regulate[] insurance." Finally, the "deemer clause," Section 514(b)(2)(B), provides that an employee benefit plan may not "be deemed to be an insurance company * * * or to be engaged in the business of insurance * * * for purposes of any State law purporting to regulate insurance companies [or] insurance contracts"; this means that state insurance regulations are *not* saved from preemption as applied to self-funded plans.

As interpreted by this Court, the "relate to" language of the preemption clause is expansive, reaching *any* state law that has more than a tenuous effect on ERISA plans. In contrast, the "regulate" language of the insurance savings clause is narrowly focused, applying only to laws that address the terms and performance of insurance contracts, rather than those that more generally affect the insurance industry. Petitioners would turn this statutory structure on its head. They would narrow the preemption clause to reach only laws that directly regulate the terms of ERISA plans, while expanding the savings clause into a safe harbor for any law that has an impact on an insurance company. This statutory sleight-of-hand should be rejected.

This Court has made clear that the preemption clause reaches any law that has a connection with an ERISA plan, or that has any effect on plans that cannot be characterized as tenuous, remote, or peripheral. Under that test, New York's surcharges plainly are preempted. It could hardly be otherwise: the surcharges have the obvious effect -- and the avowed purpose -- of manipulating the selections made by ERISA plans (along with other consumers of health services) regarding arrangements for the payment of health benefits. The surcharges thus interfere directly with ERISA welfare plans' most basic administrative decisions. They also thwart ERISA's central purpose of establishing uniformity in the regulation of plans. Multi-state plans typically use a single

nationwide benefit payor to standardize procedures and reduce costs; New York's surcharges (especially if other states imposed charges reflecting different parochial preferences) would make such an approach difficult, if not impossible.

At the same time, New York's surcharges are not saved as regulations of insurance. This Court has held that the savings clause does not reach every law that has an impact on the insurance industry. Instead, the Court looks both to whether the law can be said to regulate insurance as a matter of common sense and to whether it satisfies the three-part test for identifying the business of insurance developed under the McCarran-Ferguson Act.

The New York surcharges fail both prongs of this inquiry. As a matter of common sense, the surcharges -- which in terms address hospital rates rather than insurance contracts -- bear no resemblance to insurance regulation, which is concerned with the relationship between the insurer and the insured. As for the McCarran-Ferguson Act test, (1) the surcharges do not regulate the spreading of risk because they do not address the risk that the *policyholder* seeks to transfer; (2) they do not regulate any part of the policy relationship between the insurer and the insured, which the Court has held to be wholly separate from any arrangements between the insurer and the health care provider; and (3) by their terms the surcharges are not limited to entities within the insurance industry. The surcharges accordingly are preempted by ERISA.

ARGUMENT

I. THE SURCHARGE LAWS FALL WITHIN ERISA'S EXPRESS PREEMPTION PROVISION BECAUSE THEY "RELATE TO" EMPLOYEE BENEFIT PLANS.

Section 514(a) states that, with certain exceptions not relevant here, ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a) (1988). That provision is "conspicuous for its breadth" (*FMC Corp.* v. *Holliday*, 498 U.S. 52, 58 (1990)), and this Court has repeatedly recognized its "expansive sweep." *Pilot Life*, 481 U.S. at 47; see also *District of Columbia* v. *Greater Washington Board of Trade*, 113 S. Ct. 580, 583 (1992) (" 'deliberately expansive' language"); *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 137 (1990)("broad preemption provision"); *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 739 (1985)("broad scope"). Even petitioners are forced to acknowledge that "ERISA has broad preemptive scope." HANYS Br. 15.[6]

---

[6] Despite this statement, petitioners and their amici (see, *e.g.*, Blues Br. 28-29; HANYS Br. 15; NGA Br. 3) seek to narrow the scope of preemption by invoking the canon that a state's exercise of its police powers should not be superseded unless that is the "'clear and manifest purpose of Congress.'" *Cipollone* v. *Liggett Group, Inc.*, 112 S. Ct. 2608, 2617 (1992) (citation omitted). But that principle -- which the Court typically has utilized in the context of implied preemption -- has no application where, as here, Congress has made its intent manifest by expressly preempting state law. As this Court has stated, ERISA's preemption provision "demonstrates that Congress intended to depart from its previous legislation that 'envisioned the exercise of state regulation power over pension funds,' * * * and meant to establish pension plan regulation as exclusively a federal concern." *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522-23 (1981) (citation and footnote omitted). The only issue is one of statutory construction -- whether the challenged state law falls within the broad language chosen by Congress. See *Morales* v. *Trans World Airlines, Inc.*, 112 S. Ct. 2031, 2037 (1992).

In light of these precedents, both lower courts correctly concluded that the New York surcharge statutes are preempted by Section 514(a) because they unquestionably "relate to" ERISA benefit plans. The laws were expressly designed to affect, and in fact do affect, fundamental choices made by ERISA plan administrators; they substantially increase the costs imposed on ERISA plans; and they directly undermine Congress's goal of regulatory uniformity in the administration of ERISA plans.

A. Any State Law -- Including A "Law Of General Applicability" -- Is Preempted If It "Relates To" An ERISA Plan.

Petitioners' entire argument rests upon their attempt to manufacture a distinct ERISA preemption standard applicable to "laws of general applicability." See, *e.g.*, N.Y. Br. 13-18; Blues Br. 18-27; U.S. Br. 10-18. In petitioners' view, such measures are rarely, if ever, preempted because they virtually never have a sufficient impact on ERISA plans. See, *e.g.*, N.Y. Br. 15-17. This Court has repeatedly rejected this contention.

To begin with, there is no doubt that generally applicable laws fall within Section 514(a). That provision by its terms reaches "any and all State laws." Indeed, as this Court has observed, the statutory exemptions from preemption for laws "regulat[ing] insurance, banking, or securities" (Section 514(b)(2)(A); 29 U.S.C. § 1144(b)(2)(A)) and for "any generally applicable criminal law of a State" (Section 514(b)(4); 29 U.S.C. § 1144(b)(4)) "would have been unnecessary * * * if § 514(a) applied only to state laws dealing specifically with ERISA plans." *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983).[7]

---

[7] Furthermore, Section 514(a) preempts state laws only "insofar as they * * * relate to" plans, instead of fully superseding all state laws "that relate" to plans. The effect of that language is to preserve generally applicable laws to the extent they do *not* relate to ERISA plans. If Section

(Footnote continued)

Given this explicit statutory language, it is not surprising that the Court consistently has recognized that "a state law may 'relate to' a benefit plan, and thereby be preempted, even if the law is not specifically designed to affect such plans, or the effect is only indirect." *Ingersoll-Rand*, 498 U.S. at 139. Accord *FMC*, 498 U.S. at 58-59; *Metropolitan Life*, 481 U.S. at 62; *Pilot Life*, 481 U.S. at 47-48; *Shaw*, 463 U.S. at 98; *Alessi*, 451 U.S. at 504 ("ERISA makes clear that even indirect state action bearing on" ERISA plans "may encroach upon the area of exclusive federal concern"). See also *Morales*, 112 S. Ct. at 2038 (holding that the identical preemption provision of the Airline Deregulation Act extends to generally applicable laws on the ground that a narrow interpretation of the provision would "creat[e] an utterly irrational loophole").

To be sure, the preemption analysis is easiest with respect to state laws that affect only ERISA plans. It is a simple matter to conclude that such measures "relate to" ERISA plans and are therefore preempted by Section 514(a). But that does not mean that more general laws are immune from preemption. To the contrary, this Court frequently has found such statutes preempted. See, *e.g.*, *FMC* (ERISA preempts Pennsylvania anti-subrogation statute); *Ingersoll-Rand* (ERISA preempts Texas common-law cause of action for wrongful discharge, as applied to claim that employee was discharged to prevent his recovery of plan benefits); *Pilot Life* (ERISA preempts Mississippi common-law tort and contract causes of action asserting improper processing of claims for benefits under insured plan); *Shaw* (ERISA preempts New York civil rights law).

The Court also has recognized, however, that Section 514(a) does not preempt every state law of general

---

514(a) did not reach such laws, this limitation on the provision's preemptive effect would be unnecessary.

applicability that in any way affects an ERISA plan. ERISA leaves in place laws that have only a "tenuous, remote, or peripheral" impact on covered plans. See *Shaw*, 463 U.S. at 100 n.21. That category is narrow, however: in only one case -- *Mackey* v. *Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988) -- did the Court hold that the statute (there, a garnishment law applicable to all business entities) was not preempted. See *infra* pp. 20-21. The Court has indicated, in dicta, that "lawsuits against ERISA plans for run-of-the-mill state law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan" also may withstand preemption. *Mackey*, 486 U.S. at 833.

Thus, the question before the Court is not -- as petitioners would have it -- a novel issue regarding the status under ERISA of state laws of general applicability. It is the very same issue the Court confronted in *FMC*, *Pilot Life*, *Mackey*, *Metropolitan Life*, and *Ingersoll-Rand*: whether the challenged state law's undisputed effect on benefit plans is "too tenuous, remote, or peripheral" to satisfy the statutory standard. In addition, the Court has "repeatedly stated that a law 'relate[s] to' a covered employee benefit plan for purposes of § 514(a) 'if it has a connection with or reference to such a plan.' " *Greater Washington Board of Trade*, 113 S. Ct. at 583. See also *Ingersoll-Rand*, 498 U.S. at 139; *FMC*, 498 U.S. at 58; *Pilot Life*, 481 U.S. at 47; *Metropolitan Life*, 471 U.S. at 739. The surcharge laws are preempted under both of those tests.

B. The Surcharge Laws Have A "Connection With" ERISA Plans.

Petitioners try to create the impression that the sole argument in favor of preemption is that the surcharge laws increase the costs of ERISA plans. *E.g.*, U.S. Br. 10-18; HANYS Br. 17. It is of course true that these laws add dramatically to the costs of running ERISA plans in the State of New York -- an increase of hundreds of millions of dollars

annually. J.A. 303, 310, 327. But the effect of the surcharges on ERISA plans goes far beyond that concern. First, the laws were enacted for the specific purpose, and have the undeniable effect, of influencing fundamental decisions by ERISA plan administrators. Second, the surcharges have the effect of eliminating uniform administration of ERISA plans -- precisely the result that Congress sought to avoid in enacting the broad preemption provision. These factors establish beyond doubt the surcharges' "connection with" ERISA plans.

1. The Surcharge Laws Were Designed To Affect, And Do Affect, ERISA Plans' Choices Regarding The Method Of Providing Health Care Benefits.

As we have discussed (see *supra* pp. 6-9), the very purpose and effect of the challenged surcharges is to manipulate the selection by employee benefit plans of the most efficient arrangement for payment of health care benefits. Every choice other than the Blues is burdened by a severe financial penalty:

- if a plan chooses to self-insure, Section 2807-c operates to raise hospital reimbursement rates by 13%;
- if a plan chooses a commercial insurer, Section 348 of the Omnibus Act imposes a 24% surcharge;
- if a plan contracts with an HMO, its rates will rise as a result of the 9% HMO surcharge.

ERISA plans comprise the overwhelming majority of the customers of health care benefit payors in New York. See *supra* p. 1. When a plan sponsor considers what form of health care coverage to furnish plan participants and beneficiaries, these surcharges cannot be ignored, because cost of coverage is one of the primary considerations driving a plan sponsor's choice. J.A. 134-35. The surcharges thus have the inexorable effect of tilting ERISA plans away from

the disfavored benefit payors and toward the Blues. As the court of appeals found (Pet. App. A22):

> The 13% and 11% surcharges are designed to increase hospital costs for patients covered by health plans other than the Blues, and thus make these competing plans less attractive than the Blues. Obviously, the surcharges will affect ERISA plans' health care benefits. Likewise, the 9% assessment imposed on HMOs will interfere with a plan's selection of the most effective method to provide benefits. Thus, the surcharges purposely interfere with the choices that ERISA plans make for health care coverage.

Petitioners themselves acknowledge that the 13% and 11% surcharges were designed to make self-insurance and commercial insurance less attractive to purchasers of health care coverage in New York. Thus, the Blues frankly admit that a principal purpose of the 24% surcharge was to make purchasers of health insurance "think twice as hard" about using a commercial insurer. J.A. 207, 217-18. HANYS agrees (Br. 34) that the surcharges "might influence consumers (including ERISA plans) to elect Blue Cross coverage," and concedes that the court of appeals' finding that the surcharges "purposely interfere" with the choices made by ERISA plans is correct "[t]o some degree."

This undisputed effect establishes the surcharges' "connection with" ERISA plans. The very purpose of an employee welfare benefit plan is to "provid[e] for its participants or their beneficiaries, through the purchase of insurance or otherwise, * * * medical, surgical, or hospital care or benefits, or benefits in the event of sickness [or] accident * * *." 29 U.S.C. § 1002(1). Obviously, determining how those benefits will be provided -- whether "through the purchase of insurance or otherwise" and, if through the

purchase of insurance, selecting the type of insurance -- lies at the very heart of the administration of the plan.

Unlike a bridge toll or other state law that merely affects an ERISA plan's cost of doing business, like every other business, the surcharge laws intentionally interfere with an ERISA welfare plan's most basic administrative decision: how best to provide plan members with health care coverage. Because the surcharge laws were designed with precisely this purpose in mind, it is simply absurd to argue that they have a mere "remote, tenuous or peripheral" effect on ERISA plans. Rather, it is difficult to imagine a closer (or more disruptive) connection between a state statute and an ERISA plan.[8]

This Court has already determined that state laws that interfere with plan choices trigger ERISA preemption. *Metropolitan Life*, for example, involved a state law requiring plans "to purchase the mental health benefits specified in the statute when they purchase a certain kind of common insurance policy." 471 U.S. at 739. By tying a means of providing benefits to a particular type of benefit, the statute infringed the freedom of ERISA plans to decide for themselves how to provide benefits: a plan that wished to use insurance was forced to purchase mental health benefits. Massachusetts conceded, and this Court squarely held, that the measure was "relate[d] to" ERISA plans within the meaning of Section 514(a).

---

[8] Petitioner HANYS argues (Br. 35) that the differential should not be preempted because it is "difficult to see why Congress would regard the existence of [a choice of lower rates] as an evil to be foreclosed * * * ." But this Court had no difficulty enforcing ERISA's broad preemption provision to displace an antidiscrimination provision in New York's Human Rights Law (see *Shaw*, *supra*) "even though Congress had not expressed any intent in ERISA to approve of the employment practices that the State had banned by its statute." *Mackey*, 486 U.S. at 830. In short, "[l]egislative 'good intentions' do not save a state law within the broad pre-emptive scope of § 514(a)." *Id.* Here, moreover, the very legislative purpose is to skew the choices facing ERISA plans.

The surcharges at issue here have precisely the same effect: they intentionally infringe plans' freedom to decide how to provide benefits by increasing the cost of every choice other than the Blues. "Congress vested plan sponsors with discretion to determine whether to fund benefits 'through the purchase of insurance or otherwise.'" Kilberg & Inman, *Preemption of State Laws Relating to Employee Benefit Plans: An Analysis of ERISA Section 514*, 62 TEX. L. REV. 1313, 1336-37 (1984). State interference with this "federally mandated discretion" is preempted. *Id.*

The federal government agreed with this analysis in the court of appeals. Although it has now reversed position (without explaining why), and advances an argument squarely inconsistent with many of its prior submissions to this Court,[9] the government's former comments succinctly summarize the surcharges' impermissible effect:

---

[9] Indeed, the government's position in this case is a radical departure from its traditionally broad interpretation of Section 514(a). In its brief in *Pilot Life*, for example, the government argued in favor of preemption of a state law of general applicability on the ground that it tended to "make funding welfare plans by purchasing insurance relatively expensive compared with self-insuring." Br. 8. The government "doubt[ed] that Congress intended to create this more substantial incentive to self-insure since employees' benefits may be better protected by insured plans." *Ibid.* Here, of course, the government contends that a virtually identical effect does not trigger the protections of Section 514(a).

Moreover, in contrast to its argument here that the phrase "relate to" must be read narrowly in order to save state laws with indirect economic effects on ERISA plans, the government in the past has argued consistently that the phrase "relate to" must be read broadly. See, *e.g.*, U.S. Br. 10-12 & n.4, *Greater Washington Board of Trade*, 113 S. Ct. 580 (No. 91-1326) ("it is no longer open to question whether Section 514(a) has as broad a sweep as its dictionary definition suggests"); U.S. Br. 11, *Ingersoll-Rand*, 498 U.S. 133 (No. 89-1298); U.S. Br. 8-9, *Mackey*, 486 U.S. 825 (No. 86-1387); U.S. Br. 11, *Ft. Halifax Packing Co.* v. *Coyne*, 482 U.S. 1 (1987) (No. 86-341) ("This Court has concluded that 'relates to' in Section 514(a) must be read broadly, as the normal meaning of the phrase suggests * * * ."); U.S. Br. 24-26, *Alessi*, 451 U.S. 504 (No. 79-1943).

> [T]he surcharges have a "connection with" plans, for their intent and effect is to alter plan behavior. The surcharges are designed to induce self-insured plans to become insured, in order to avoid the 13% surcharge, and to encourage already-insured plans to purchase coverage from the Blues, in order to avoid the 13% and 11% charges. Finally, plans that contract with HMOs are given a strong incentive to rewrite their plan documents so as to cover more Medicaid recipients and reduce or eliminate the 9% surcharge. *Shaw*, *Metropolitan [Life]* v. *Massachusetts* and *General Electric* v. *New York Dep't of Labor* all hold that such changes in plan structure and benefit levels constitute the requisite "connection" for purposes of § 514.

Gov't C.A. Br. 19-20.

In contending nonetheless that the surcharge laws do not "relate to" ERISA plans, petitioners assert (HANYS Br. 17) that *Mackey* is the case "most closely analogous" to this one. Because the Court rejected the claim of preemption in *Mackey*, petitioners argue, it should reach the same conclusion here. That assertion misunderstands both the decision in *Mackey* and the fatal flaw in the surcharge laws.

The Court did not hold in *Mackey* that state laws that increase the costs borne by ERISA plans are never preempted. The question in *Mackey* was whether an ERISA plan could be subjected to a garnishment action. Although the argument in favor of preemption rested in part on the "substantial administrative burdens and costs" imposed upon the plan by the garnishment process (486 U.S. at 831), the Court's analysis turned entirely on the detailed civil enforcement scheme set forth in ERISA itself.

The Court found that Congress clearly contemplated that ERISA plans could be sued, and money judgments awarded against them. 486 U.S. at 832-33. In certain types of civil

actions,[10] however, ERISA does not provide an enforcement mechanism for collecting such judgments. The Federal Rules of Civil Procedure, applicable in this context, defer to state collection methods, and the Court therefore concluded that these state laws were not preempted: "otherwise, there would be no way to enforce such a judgment won against an ERISA plan." *Id.* at 834. Because garnishment is simply a permissible method of collecting a money judgment, the Court refused to find it preempted for the same reason. In addition, the Court observed that ERISA contains an express anti-assignment provision that does not apply to garnishment. In sum, the result in *Mackey* was based upon the literal language of ERISA, which makes clear that the preemption provision does not reach garnishment proceedings.

Even if *Mackey* did rest on a conclusion that the monetary and administrative burdens imposed upon the plan by garnishment were too "remote, tenuous or peripheral" to trigger preemption -- something that seems improbable in view of the fact that garnishment has the quite direct effect of barring a plan from paying benefits to a beneficiary -- that conclusion would be inapplicable to the massive surcharges at issue here. Unlike a state law applicable to business entities generally (*e.g.*, a property tax or minimum wage law, which increases plan costs in a nondiscriminatory manner), the surcharge laws *purposefully discriminate among benefit payors* in order to influence the choices made by ERISA plans. That direct, and intentional, interference with plans' freedom of choice plainly establishes the requisite "connection" between the state laws and ERISA plans.[11]

---

[10] That is, so-called "run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan." *Mackey*, 486 U.S. at 833.

[11] Petitioners rely (*e.g.*, Blues Br. 15, 23-27) on *United Wire, Metal & Machine Health & Welfare Fund* v. *Morristown Memorial Hospital*, 995 F.2d 1179 (3d Cir.), cert. denied, 114 S. Ct. 382 (1993). But the Third

(Footnote continued)

2. The Surcharge Laws Obstruct Congress's Goal Of Regulatory Uniformity By Producing State-Created Differences Among Benefit Payors That Impel Sponsors Of Multi-State ERISA Plans To Tailor Their Conduct To New York Law.

There is a second, and equally powerful, reason why the New York laws have a "connection with" ERISA plans: they directly contravene the congressional purposes of establishing uniform federal regulation of ERISA plans and avoiding the conflicts and administrative inefficiencies that would invariably result if employers were required to "tailor[]" their plans to the "peculiarities of the law of each jurisdiction." *Ingersoll-Rand*, 498 U.S. at 142. See also *FMC*, 498 U.S. at 60 ("[t]o require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits"); *Shaw*, 463 U.S. at 105 ("[b]y establishing benefit plan regulation 'as exclusively a federal concern,' * * * Congress minimized the need for interstate employers to administer their plans differently in each State in which they have employees").

The surcharge laws have the precise effect that Congress sought to prevent. Many of the plans affected by the surcharge laws are multi-state plans covering employees located in states other than New York. J.A. 117-21, 125-26, 129-30, 133-34, 136-37, 139-40, 141-42, 144-45. These plans frequently prefer to deal with a single nationwide benefit payor in order to standardize procedures and thereby reduce

---

Circuit acknowledged that a law relates to an ERISA plan if it is "specifically designed to affect employee benefit plans" (*id.* at 1192); there simply was no evidence that the challenged New Jersey law was designed to influence ERISA plan choice regarding particular forms of health coverage. Here, of course, that was the conceded purpose of the surcharge laws.

administrative costs. In addition, multi-state plans can use their buying power in the national insurance market to obtain better terms from benefit payors.

The state-created cost differential, however, puts a plan in the position of choosing between incurring higher benefit payor costs (by selecting a New York benefit payor other than the Blues) or higher administrative costs (by selecting the Blues in New York and another benefit payor for the rest of the country). And if New York is free to tilt plan choice toward a favored benefit payor in this manner, other states may do so as well. Parochial preferences established by various states could have the practical effect of forcing plans to forgo entirely the option of a nationwide plan in favor of choices dictated by these state preferences. Allowing states to alter the relative costs of different types of benefit payors would thus require plans to "tailor[]" their plans to the "peculiarities of the law of each jurisdiction," thereby thwarting Congress's goal of nationwide uniformity.

Petitioners' only response is to point out that hospital costs would vary from region to region with or without regulation. See, *e.g.*, N.Y. Br. 22-23; Blues Br. 21-22. But the fact that costs may vary from place to place because of market factors does not give a state license to step in and artificially alter the relative costs of different types of benefit payors. The surcharges are designed to -- and do -- produce *state-created* disuniformity that burdens multi-state plans' attempts to take advantage of the efficiencies of the national market. Under the Court's precedents, that burden constitutes a "connection with" covered plans sufficient to trigger ERISA preemption. See *FMC*, 498 U.S. at 58-59; *Alessi*, 451 U.S. at 524-25.

3. The Surcharges Are Not Immune From Preemption Because They Affect Plans Through Economic Incentives Rather Than Direct Regulation.

Petitioners do not dispute that a New York law would be preempted if, for example, it required ERISA plans to use the

Blues to provide health insurance. The crux of their submission is that "[t]here is a legally significant distinction between influencing plan choice and mandating plan conduct." N.Y. Br. 27. That assertion defies both common sense and this Court's precedents.

Petitioners concede that the surcharges were designed to influence plan choice in determining whether to provide plan members with health care coverage through self-insurance, an HMO, commercial insurance or Blue Cross coverage. But what if the 24% differential were not enough to "influence choice" to a degree that the Blues' competitive position improved? If the State were to respond with a 100% or a 1000% surcharge, could one still say that it was merely "influencing choice" as opposed to "mandating conduct?"

Petitioners' position, if accepted by this Court, would gut ERISA's preemption provision by allowing states to use draconian penalties to do indirectly -- control the decisions of ERISA plans -- precisely what they may not do through direct regulation. Indeed, given petitioners' view, Massachusetts could have avoided the "connection" ruling in *Metropolitan Life* if, instead of requiring that plans using insurance provide mental health benefits, it simply had imposed a substantial surcharge on insurance policies that omitted mental health benefits.[12]

Such sterile formalism simply makes no sense. As this Court has recognized, "ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the preemption provision." *Alessi*, 451 U.S. at 525. Petitioners' approach would instead elevate form over substance.

---

[12] Petitioner HANYS attempts to distinguish *Metropolitan Life* on the ground that it left plans "*without* a choice." Br. 36 (emphasis in original). In fact, although Massachusetts did not use financial incentives to influence plan conduct, it did leave plans a choice: the purchase of mental health benefits was mandatory only if a plan "purchase[d] a certain kind of common insurance policy." 471 U.S. at 739. Thus, ERISA plans operating in Massachusetts could have avoided the law by self-insuring.

In other areas of the law, the Court has not distinguished between monetary levies and direct regulation, recognizing that the former may have precisely the same practical effect as the latter. Thus, the Court has acknowledged that state tort rules -- which simply impose monetary burdens -- have the same practical effect as state regulations for purposes of preemption. See, *e.g.*, *Cipollone*, 112 S. Ct. at 2620. And taxes can run afoul of constitutional limits on state authority, such as the First Amendment and the Commerce Clause, even though they only "influence choice" and do not "mandate conduct."

In sum, the surcharge laws have the purpose and effect of driving the sponsors or administrators of ERISA plans operating in New York to provide plan members with their health coverage through the Blues rather than commercial insurance or self-insurance. This blatant interference with the administration and structure of ERISA plans and the plan sponsors' strategy concerning the most effective method of providing benefits constitutes a sufficient "connection with" ERISA plans to warrant preemption.

Finally, unable to defend the New York statutes on any other ground, petitioners and their amici rely on a lengthy parade of horribles in arguing that affirmance of the decision below will automatically lead to preemption of numerous generally applicable state laws with indirect economic impacts on ERISA plans as well as virtually all state health care regulation. These predictions are demonstrably false.

What is at issue here is a state's ability to pass laws intended to influence what is probably an ERISA welfare plan's most fundamental administrative determination: how best to provide plan members with health care coverage. None of the other regulations cited by the State or its amici comes close to having that kind of manipulative effect.

Indeed, we know of no other state law that is specifically designed to force ERISA plans to the state's favored health

insurer. Thus, twelve states appearing as amici curiae observe that "hospital rate-setting programs across the country differ significantly from the New York surcharges, and * * * many states are engaging in other forms of properly authorized health care-related activities on behalf of their citizens." States Br. 28. These states recognize that the Court can rule narrowly here, urging the Court to base its decision on "the characteristics presented solely by the New York system." *Ibid.* (footnote omitted).

This case simply does not require the Court to decide whether a state law that produces an across-the-board increase in the cost of medical services -- and that is not crafted with the purpose and effect of influencing fundamental ERISA plan choices -- is preempted because it has an indirect economic impact on ERISA plans. The Court "need not determine the outer bounds of ERISA's pre-emptive language to find this [New York] provision an impermissible intrusion on the federal regulatory scheme." *Alessi*, 451 U.S. at 525.[13]

---

[13] Petitioners and their amici cite *NYSA-ILA Medical and Clinical Services Fund* v. *Axelrod*, 27 F.3d 823 (2d Cir. 1994), petition for cert. filed, 63 U.S.L.W. 3371 (U.S. Oct. 21, 1994) (No. 94-745), and *New England Health Care Employees' Union, District 1199* v. *Mt. Sinai Hosp.*, 846 F. Supp. 190 (D. Conn. 1994), app. pending, Nos. 94-7264, 94-7906 (2d Cir.), as purported examples of how the instant case will lead to the demise of hospital rate regulation and regulation in the health care area generally. See, *e.g.*, Blues Br. 22-23 n.19 (citing the foregoing cases as examples of challenges to hospital and insurance regulations premised on the "irrational ramifications" of the court of appeals' ruling in this case). These cases, however, present fact situations entirely different from the one at bar. *NYSA-ILA* involved a direct tax on ERISA plan contributions and payments intended to pay for participants' medical benefits. *New England Health Care* involved a challenge to Connecticut's Uncompensated Care Pool Act. New York has an uncompensated care provision in its hospital rate structure, but this case does not challenge it. These entirely different issues can and will be addressed on the basis of the records compiled in those cases.

C. The Surcharge Laws "Refer to" Self-Insured ERISA Plans.

The 13% surcharge, in addition to suffering from the infirmities discussed above, is preempted for the further reason that it refers expressly to self-insured ERISA plans. Section 2807-c(1)(b) imposes the 13% surcharge on the hospital bills of patients "enrolled in a self-insured fund * * *." Pet. App. A102. Under this Court's precedents, that reference is sufficient to invoke preemption under Section 514(a).

The Court has held that "any state law imposing requirements by reference to [ERISA plans] must yield to ERISA." *Greater Washington Board of Trade*, 113 S. Ct. at 582-83 (footnote omitted). Accord *Mackey*, 486 U.S. at 838 n.12. It is true that the New York Legislature did not use the phrase "ERISA plans" or "employee welfare benefit plans" in Section 2807-c(1)(b). But that does not preclude preemption. In *FMC*, the Court found preempted a Pennsylvania law that referred to "[a]ny program, group contract or other arrangement for payment of benefits," even though the statute did not explicitly refer to "ERISA plans" or "employee welfare benefit plans subject to ERISA." 498 U.S. at 59. Because the Pennsylvania statute obviously encompassed ERISA plans, it "ha[d] a 'reference' to" those plans within the meaning of ERISA's preemption clause. *Ibid.*

More recently, in *Greater Washington Board of Trade*, the Court held preempted a District of Columbia workers' compensation statute that provided:

> Any employer who provides health insurance coverage for an employee shall provide health insurance coverage equivalent to the existing health insurance coverage of the employee while the employee receives or is eligible to receive workers' compensation benefits under this chapter.

113 S. Ct. at 582 (quoting D.C. Code Ann. § 36-307(a-1)(1)). The Court found that this statute specifically referred to

ERISA plans "and on that basis alone is pre-empted." *Ibid.* Under *FMC* and *Greater Washington Board of Trade*, the conclusion is inescapable that Section 2807-c(1)(b), as applied to self-insured funds, "refers to" ERISA plans and is preempted.

D. This Court Should Reject Petitioners' Invitations To Rewrite Section 514(a).

Apparently recognizing that the surcharge laws fit squarely within the language of Section 514(a) as construed in this Court's precedents, petitioners urge the Court to narrow the scope of that provision. These pleas for relief, which rest principally on policy grounds, should be addressed to Congress. They provide no reason for this Court to overturn its prior decisions.[14]

First, petitioner HANYS argues (Br. 19-23) that there is no evidence that Congress intended to enact a preemption provision broad enough to encompass the surcharge laws. As the Court has repeatedly observed (see *supra* p. 12 & n.6), however, the broad statutory language is the best evidence of Congress's intent. The legislative history also makes clear that Congress knew just what it was doing. The preemption provision that became Section 514(a) was added in the Conference Committee. H.R. Conf. Rep. No. 1280, 93d

[14] Indeed, we note that Congress has continued to scrutinize the impact of the ERISA preemption provision on health care reform efforts at the state level. See, *e.g.*, S. 3180, 102d Cong., 2d Sess. (1992) (bill establishing a federal commission to grant limited waivers from Section 514(a) to states that enacted comprehensive health care reform laws); S. 2452, 103d Cong., 2d Sess. (1994) (bill that would amend ERISA to "provide the states with the flexibility to continue their reform efforts"). A House committee held hearings on this subject as recently as November 30, 1994. See 1994 Daily Labor Report, *Current Developments* d12 (Dec. 1, 1994). The fact that Congress has focused on this question diminishes even further petitioners' argument that this Court should alter its long-standing construction of Section 514(a) in order to achieve allegedly beneficial policy goals.

Cong., 2d Sess. 82 (1974), *reprinted in* 3 Senate Committee on Labor and Public Welfare, Legislative History of the Employee Retirement Income Security Act of 1974, at 4357 (Committee Print 1976) (Legislative History). That Committee also included in the bill a provision creating a Joint Pension Task Force (Task Force). The Task Force was directed to make a "full study and review" of various topics and present a report to Congress. One of those topics was "the effects and desirability of the Federal preemption of State and local law with respect to matters relating to pension and similar plans." 3 Legislative History at 4476.

Congress was well aware that it was taking a bold step when it amended ERISA's preemption provision to sweep aside all state laws "relat[ing] to" employee benefit plans: the conferees explicitly stated that they "recogniz[ed] the dimensions of such a policy." *Id.* at 4771. That undoubtedly is why the Task Force was assigned the job of studying preemption. "If it is determined," the conferees noted, "that the preemption policy devised has the effect of precluding essential legislation at either the State or federal level, appropriate modifications can be made." *Ibid.* The Court has observed that "the [Task Force] Report expressed approval of ERISA's broad pre-emption of state law, explaining that 'the Federal interest and the need for national uniformity are so great that enforcement of state regulation should be precluded.'" *Shaw*, 463 U.S. at 99 n.20 (quoting H.R. Rep. No. 1785, 94th Cong., 2d Sess. (1977)). Indeed, "[t]he Report recommended only that the exceptions described in § 514(b) *be narrowed still further*." *Ibid.* (emphasis added).[15]

[15] Petitioner HANYS rummages (Br. 20-23) through ERISA's legislative history in search of evidence that Congress did not intend to preempt state laws like the surcharges. First, HANYS asserts (Br. 21) that "the Conference Report referred to state laws directly pertaining to employee benefit plans," such as disclosure and fiduciary requirements, in providing examples of preempted laws. But, as we have discussed (see *supra* p. 14),

(Footnote continued)

Petitioners also urge the Court to recognize a "health care law" exception to Section 514(a). Specifically, petitioner HANYS pieces together (Br. 29-33) various bits of congressional action relating to the Medicare and Medicaid programs in an effort to show that Congress could not have intended ERISA's preemption clause to supersede state laws regulating hospital costs or health care.

This contention has an Alice-in-Wonderland quality. A principal purpose of employee welfare benefit plans is to furnish health care for plan participants and their beneficiaries. In view of the fact that covered plans furnish health care benefits, Congress must have understood that many state health care laws would "relate to" covered plans. If Congress

---

this Court has concluded that the preemption provision reaches laws with an indirect but nonetheless real effect on ERISA plans. Indeed, "to interpret the pre-emption clause to apply only to state laws dealing with the subject matters covered by ERISA, such as reporting, disclosure, and fiduciary duties, would be incompatible with the provision's legislative history" because the limited preemption clauses contained in earlier versions of the bill "were rejected in favor of the present language in the Act, 'indicat[ing] that the section's pre-emptive scope was as broad as its language.'" *FMC*, 498 U.S. at 58-59 (footnote omitted) (quoting *Shaw*, 463 U.S. at 98).

Next, HANYS seizes (Br. 21) on Rep. Dent's reference to the Health Maintenance Organization Act and cites that as a basis for limiting the preemptive reach of ERISA. But HANYS conveniently ignores Rep. Dent's statement -- made practically in the same breath -- that "the provisions of section 514 would reach any rule, regulation, practice or decision of any State, subdivision thereof or any agency or instrumentality thereof -- including any professional society or association operating under code of law -- *which would affect any employee benefit plan*." 3 Legislative History at 4670-71 (emphasis added). Thus, the snippet of legislative history that HANYS highlights to "confirm" its position on ERISA preemption actually contradicts it. The second problem with HANYS's point is that the HMO Act's painstaking recitation of the types of state laws intended to be displaced shows (just like ERISA's doomed predecessor bills) that Congress knew how to craft a limited preemption provision when it wanted to do so. In the case of ERISA, however, it deliberately chose to do the opposite.

meant to reserve health care laws exclusively to state concern, it surely would have included that category of laws in the savings clause, along with laws regulating insurance, banking and securities. Because Congress did not take that step, the status of health care laws must be evaluated, like other state laws, on a case-by-case basis. Some are preempted; others are not.

This point is made clear by the Court's summary affirmance in *Agsalud* v. *Standard Oil Co.*, 454 U.S. 801 (1981). In that case, the State of Hawaii passed the "Hawaii Prepaid Health Care Act," which required workers in the state "to be covered by a comprehensive prepaid health care plan." *Standard Oil Co.* v. *Agsalud*, 442 F. Supp. 695, 696 (N.D. Cal. 1977), aff'd, 633 F.2d 760 (9th Cir. 1980), aff'd, 454 U.S. 801 (1981). Standard Oil challenged the Hawaii law on the ground that it was preempted by ERISA. The district court noted that ERISA's legislative history "contains no unambiguous evidence that Congress did not intend to preempt [health insurance laws]." 442 F. Supp. at 706. The court found that the only "sure guide" to Congress's intent is the language used in the preemption provision, "and that language clearly means that ERISA preempts state health insurance laws." *Ibid.* The Ninth Circuit and this Court, in turn, affirmed.

Congress's reaction to the *Standard Oil* decision is highly significant. It did not amend ERISA's preemption clause to change the "relate to" standard, and it did not amend ERISA's savings clause to carve out all health care laws. Rather, Congress exempted only the Hawaii Prepaid Health Care Act. See 29 U.S.C. § 1144(b)(5)(B)(ii) (1988).[16] That course of action provides further evidence that laws operating in the

---

[16] In granting this exemption from Section 514(a), Congress made clear its limited scope. Any amendments to the Hawaii statute after September 2, 1974, are not exempt from preemption. *Id.* Furthermore, the exemption "shall not be considered a precedent with respect to extending such amendment to any other State law." Pub. L. No. 97-473, § 301(b), 96 Stat. 2605, 2612 (1983).

health care or health insurance fields do not enjoy any special immunity from ERISA's preemption provision.

II. THE SURCHARGE LAWS ARE NOT SAVED FROM PREEMPTION BECAUSE THEY DO NOT "REGULATE[] INSURANCE."

As discussed in Part I, petitioners ask this Court to rewrite Section 514(a) to preempt only those state laws that mandate "requirements" for ERISA plans, rather than "any and all State laws [that] relate to" plans. Similarly, petitioners ask this Court to revise and expand Section 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A), the clause that saves from preemption only those state laws that "regulate[] insurance." As we explain below, this aspect of petitioners' argument is equally foreclosed by the statutory language and the decisions of this Court.

Petitioners candidly acknowledge that the 13% and 11% surcharges were designed to influence ERISA plans' choices of health care coverage (HANYS Br. 40-41); for that very reason, petitioners contend that the surcharges "regulate[] insurance."[17] The accuracy of petitioners' concession, however, does not transform the surcharge law into a *regulation of insurance*.

Petitioners seem to recognize that the language of the savings clause is difficult to square with their argument. As a consequence, they insist that the clause saves all state laws that "relate to" or "affect" insurance.[18] But that is not what the

---

[17] Petitioners do not argue that the 9% surcharge is saved from preemption as a law regulating insurance, and for good reason: New York -- which enforces the statute -- frankly concedes (Br. 30 n.22) that the 9% surcharge "regulates HMOs as providers of managed medical care, not as insurers."

[18] See, *e.g.*, Blues Br. 35 (surcharges are saved because they are "designed to affect" insurance); *id.* at 37 ("affected"); *id.* at 38 ("affect" insurance relationship); N.Y. Br. 31 (surcharges are "connected to a payor's status in the insurance marketplace"); HANYS Br. 37 *et seq.* (explicitly equating "relate to" with "regulates"); *id.* at 40 (equating "affect" with "regulate").

statute says: the savings clause does not sweep in every state law that "ha[s] an impact on the insurance industry." *Pilot Life*, 481 U.S. at 50. On the contrary, the clause merely "protect[s] state insurance regulation of insurance contracts purchased by employee benefit plans." *FMC*, 498 U.S. at 64; see *id.* at 62-63.

The power that is saved from ERISA preemption -- like that preserved in the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.* -- extends only to state regulation of the policy relationship between the insurer and the insured. *Metropolitan Life*, 471 U.S. at 740. The surcharge laws, however, have nothing to do with the policy relationship, but rather regulate hospital rates in an attempt to force ERISA plans to provide health benefits through the Blues. As such, the surcharges do not "regulate[] insurance" under the analysis that this Court consistently has applied, and therefore are not saved from preemption.

A. The Surcharges Do Not "Regulate[] Insurance" Under The Analysis Consistently Applied By This Court.

To determine whether a law comes within the ERISA savings clause, this Court first considers whether the state law "regulates insurance" under the common-sense meaning of those terms. *Pilot Life*, 481 U.S. at 48. Then, the Court pursues a three-part inquiry developed to interpret the "similarly worded protection" afforded by the McCarran-Ferguson Act. *Ibid.* See *Metropolitan Life*, 471 U.S. at 743-44 & n.21. The Court examines,

> *first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.

Id. at 743 (citing *Union Labor Life Insurance Co.* v. *Pireno*, 458 U.S. 119, 129 (1982), and *Group Life & Health Insurance*

Co. v. *Royal Drug Co.*, 440 U.S. 205 (1979)) (emphasis in original).[19] Under these controlling standards, the hospital surcharges do not regulate insurance.

1. The Surcharges Do Not "Regulate[] Insurance" Under A "Common-Sense View."

The threshold inquiry under the ERISA saving clause is whether a statute regulates insurance under a common-sense view of the matter. *Metropolitan Life*, 471 U.S. at 739-40. Applying common sense, it is evident that New York's unique surcharge laws bear no resemblance to traditional insurance regulation. Indeed, New York -- the regulating authority -- admitted in the Second Circuit that the 13% surcharge did not regulate insurance. N.Y. C.A. Br. 33 n.42. Although the State resists that logical conclusion here, it nevertheless forthrightly concedes that the surcharge law is a "hospital rate-setting statute," not an insurance regulation. N.Y. Br. 31; see also, *e.g.*, *id.* at 4, 16; *id.* at 9-11 *et passim* (surcharges are "health care assessments"); N.Y. C.A. Br. 22 (surcharge "statute regulates only the cost of hospital care services, requiring hospitals to bill patients at certain rates"); *id.* at 33 n.42.

This Court's precedents reinforce this common-sense conclusion. Recently the Court reconfirmed that the regulation of insurance focuses on the contractual "relationship between the insurance company and its policyholders." *Fabe*, 113 S. Ct. at 2208.[20] See *Metropolitan Life*, 471 U.S. at 740 (a

[19] The government is mistaken in suggesting (Br. 20) that only a "common-sense" assessment is necessary. In the sole case cited to support that claim, the parties *did not contest* the application of the savings clause. *FMC*, 498 U.S. at 60. Moreover, although this Court stated in passing that none of the three McCarran-Ferguson factors "is *necessarily* determinative in itself," *Pireno*, 458 U.S. at 129, each statute or practice that the Court has held to be within the "business of insurance" in fact satisfied all three criteria. See, *e.g.*, *United States Department of Treasury* v. *Fabe*, 113 S. Ct. 2202, 2209 (1993); *Metropolitan Life*, 471 U.S. at 743.

[20] Even a law that is specifically directed at the insurance industry does not always "regulate" insurance. See, *e.g.*, *Fabe*, 113 S. Ct. at 2202

(Footnote continued)

mandated-benefits law that "regulates the terms of certain insurance contracts" is saved); *Pilot Life*, 481 U.S. at 51 (a common-law cause of action that "does not define the terms of the relationship between the insurer and the insured" is not saved); *FMC*, 498 U.S. at 61 (an anti-subrogation law that "directly controls the terms of insurance contracts" is saved). The relationship between an insurer and a hospital or other service provider is "wholly separate" from the relationship between an insurer and its insured. *Royal Drug*, 440 U.S. at 216 n.14; see *Fabe*, 113 S. Ct. at 2212. It is "next to impossible to assume that Congress could have thought" that the "purchase" by insurance companies "of goods and services from third parties" is "insurance," or that an unusual law that prescribes or regulates payments to those third parties "regulates insurance." *Royal Drug*, 440 U.S. at 230.

Regulatory provisions that address "the relationship between insurer and insured" include controls over "the type of policy" that can be issued, "its reliability, its interpretation, and [its] enforcement." *Metropolitan Life*, 471 U.S. at 743-44. In short, for the purpose of the savings clause, state laws that "regulate insurance" govern the formation, terms, and performance of the insurance contract. To ensure the integrity of contract formation and performance, that regulation may address the financial management of an insurance company, and the sale and advertising of insurance. See *id.* at 728.

Although New York's Insurance Law contains many such regulations, the surcharge laws are of another ilk. They do *not* impose *any* requirement on insurance companies or establish *any* of the terms of insurance contracts. Instead, they simply dictate the rates that a hospital must charge a patient, penalizing consumers and ERISA plans that use disfavored

(although the challenged law at issue applied only to insurance companies, it regulated insurance only to extent it governed the insurer-policyholder relationship); *National Securities, Inc.* v. *SEC*, 393 U.S. 453 (1969) (laws regulating insurance company mergers did not regulate insurance).

methods to provide for their medical expenses. Although the surcharges may lend support to a politically favored participant in New York's insurance marketplace, that market distortion does not transform the surcharge laws into "regulations of insurance." See *Pilot Life*, 481 U.S. at 50.

For a related reason, there is no merit to the government's suggestion (Br. 24) that the surcharges are saved because they are "designed to affect the calculation of insurance rates by reducing the cost differential that existed between the Blues and the other insurers." Until this case, the government consistently recognized that a State's attempt to reduce insurers' costs was *not* a regulation of insurance. U.S. Br. 20, *Fabe* (No. 91-1513); see also U.S. Br. 14 n.14, *Pireno* (No. 81-389); U.S. Br. 30, *Royal Drug* (No. 77-952). A surcharge on the rates that hospitals charge patients does not "regulate insurance," regardless of its effect on insurers' costs. Although the law will make commercial insurance more expensive and therefore may lead insureds to seek other coverage, that indirect consequence does not "regulate" insurance in any common-sense way. See *Fabe*, 113 S. Ct. at 2212.

Rather than confront the statutory requirement that state laws actually "regulate insurance" in order to be saved from ERISA preemption, petitioners seek to turn Section 514 on its head, confusing the breadth of the preemption provision with the narrow scope of the savings clause. Having argued that only state laws that single out and directly *regulate* ERISA plans *"relate to"* plans for the purposes of the preemption clause, petitioners and the United States now insist that any state law that *relates to* the insurance market "*regulates* insurance" and therefore is saved from preemption. See, *e.g.*, HANYS Br. 37 *et seq.* (arguing that all laws that "relate to" insurance therefore "regulate" it). Indeed, the government suggests that it is enough that the surcharge laws are "related to traditional objectives of insurance regulation, such as risk spreading, regulating rates, and ensuring solvency of

insurers." U.S. Br. 23 (footnotes omitted).[21] As this phrasing implicitly concedes, however, the hospital surcharges in fact do *not* actually regulate risk spreading, insurance rates, or the solvency of insurers.

Because the surcharges are far "removed from the contractual relationship between the policyholder and the insurance company" (*Fabe*, 113 S. Ct. at 2216 (Kennedy, J., dissenting)), they are not within the common-sense conception of laws that regulate insurance. Because they cannot pass that analytical threshold, the surcharges are not saved from preemption by Section 514(b)(2)(A).

2. *The Surcharges Do Not Satisfy The Additional Criteria Set Forth In* Metropolitan Life.

Even if the surcharges could be said to regulate insurance under a common-sense view, they cannot survive scrutiny under the three additional factors that this Court used in *Metropolitan Life* and *Pilot Life*. Petitioners argue that, although this Court consistently has used those factors in its analysis of the ERISA savings clause, that clause is in fact broader than the similar savings clause in the McCarran-Ferguson Act, and the three-factor analysis must be modified. See, *e.g.*, Blues Br. 34-35; U.S. Br. 20. See *infra* pp. 44-48. This desperate attempt to escape the McCarran-Ferguson test

---

[21] This position again marks a striking *volte-face* for the United States. In the past, the government argued successfully that a "common-sense interpretation" of the word "regulates" does not mean that the savings clause preserves every law that may "relate to" insurance, for sound reasons rooted in the text of ERISA: the limited scope of the savings clause is evident upon "comparison of the word 'regulate' in the saving clause with Congress's use of the phrase 'relates to' in the preemption clause. If Congress had intended to preserve state laws affecting insurance matters as broadly as it intended to preempt state laws affecting benefit plans, it could have used the phrase 'relates to' in the saving clause." U.S. Br. 14, *Pilot Life* (No. 85-1043).

is understandable: as four judges below unanimously concluded, the surcharges cannot survive that inquiry.

a. The surcharges do not regulate the transfer or spreading of policyholders' risk.

The surcharges quite plainly do not "regulate[] the spreading of risk." *Metropolitan Life*, 471 U.S. at 743. The relevant risk is "the risk the *policyholder* seeks to transfer in an insurance contract." *Fabe*, 113 S. Ct. at 2216 (Kennedy, J., dissenting) (emphasis added); see also *id.* at 2209 (opinion of the Court). Unlike the mandated-benefit law in *Metropolitan Life*, the hospital surcharges do not address that risk at all, but simply distort the prices ultimately paid to health care providers by some insurers and other persons.

In both *Royal Drug* (440 U.S. at 214) and *Pireno* (458 U.S. at 130), this Court held that efforts to control provider health care costs reimbursed by insurers did not involve the spreading of the relevant risk. It made no difference that such cost containment might enable insurers to charge lower premiums that would make insurance more affordable to a wider group of people, and thus potentially would allow greater risk-spreading on behalf of persons not yet insured.

The arrangement at issue in *Royal Drug* was functionally similar to the rate regulation at issue here: *Royal Drug* involved a private price agreement between insurers and providers, while in this case the State imposes the surcharge rate that hospitals must charge patients' insurers or other group benefit payors. The agreement in *Royal Drug* also involved the relationship between an insurer and a provider of health care services, but this Court held that such an agreement did not spread or transfer *policyholders'* risks. Rather, the risk affected was the obligation to reimburse drug costs, a risk that the insurer had assumed separately in its insurance contracts. 440 U.S. at 213-14 & n.12.

The surcharges at issue in this case are even farther removed from the risk-spreading function of insurance, because they directly address only the rates that hospitals charge patients. To the extent they involve insurance at all, the surcharges involve the same insurer-provider relationship at issue in *Royal Drug*; they do not regulate the transfer of policyholders' risks. They merely raise the cost of hospital services and, hence, the insurer's cost of satisfying its obligations on a risk it has already assumed.

Nevertheless, the courts below erroneously concluded that the surcharges have the effect of transferring or spreading policyholder risk merely because they might prompt "ERISA plans to shift to the Blues." Pet. App. A28. Whatever the secondary effects may be in terms of market distortion, the surcharges themselves do not regulate the "transfer of risk from insured to insurer * * * by means of the contract between the parties." *Fabe*, 113 S. Ct. at 2209 (quoting *Pireno*, 458 U.S. at 130). The surcharges transfer funds to the State and the hospitals from ERISA plans and other insurance purchasers, but do not regulate policyholders' risks at all.

b. The surcharges do not regulate any integral part of the policy relationship between insurer and insured.

Not only do the surcharges fail to regulate the transfer of policyholder risk; they also do not "regulate an integral part of the relationship between the insurer and the policyholder." *Metropolitan Life*, 471 U.S. at 743. Rather than "limiting the type of insurance that an insurer may sell to the policyholder" (*ibid.*), the surcharges attempt to influence ERISA plans to purchase insurance from a favored source.

Both lower courts correctly held that the surcharge laws do not regulate any practice that is integral to the policy relationship between the insurer and the insured. Pet. App. A26, A79. Indeed, New York conceded this point before the Second Circuit. C.A. Br. 36 n.47. Before this Court, however, New York now joins the other petitioners in contending (Br.

35) that the surcharge laws regulate an integral part of the relationship between the insurer and the insured, "albeit indirectly," because they "encourag[e] community rating and open enrollment." Those features, in turn, "ensur[e]" that a policy relationship may be formed independent of actuarial factors. *Ibid.* This argument cannot withstand scrutiny.

In the first place, hospital rate surcharges do not regulate any part -- much less an integral part -- of the policy relationship between the insurer and the insured. That result is not affected by the possibility that some insurers' costs may be reduced, and along with them the cost of health insurance for some applicants. In *Royal Drug*, this Court specifically held that agreements governing an insurer's payments to health care providers did not affect an integral part of the relationship between insurer and insured; it did not matter that the agreements lowered the insurer's cost of satisfying its policy obligations to its insureds, and thus might lower the cost of insurance. 440 U.S. at 215-17. The Court explained that the policy relationship between insurer and insured is "wholly separate" from the contractual arrangement between insurer and health care provider. *Id.* at 216 n.14; see also *Pireno*, 458 U.S. at 131. The surcharge laws at issue here set only the reimbursement rate for "payments to general hospitals" (New York Public Health Law, Section 2807-c(1)(b)) -- a transaction that likewise is clearly distinct from the obligations of an insurer to its insured.

In addition, although "[c]ommunity rating and open enrollment" may indeed "play an integral role in the policy relationship between insurer and insured," the surcharges simply increase the prices that hospitals charge patients with certain health coverage, and do not *regulate* community rating or open enrollment in any way. New York certainly knows how to accomplish the aims it espouses here: New York Insurance Law § 3231 expressly requires that commercial insurers engage in open enrollment and community rating in

the small group market. See *supra* p. 7 n.5. That law clearly regulates the affected insurance contracts.

By contrast, the surcharge laws do not change any of the terms, conditions, or scope of coverage in any insurance contract, they do not regulate the formation of insurance contracts, and they do not govern or seek to secure insurers' performance of their obligations to policyholders. Indeed, nothing in the surcharges even gives an insurer or other payor an incentive to offer community rating or open enrollment. HMOs already offer both features, yet they are still subject to the 9% surcharge. Self-insured plans must pay the 13% surcharge even though they are not licensed insurers and cannot engage in community rating or open enrollment. Commercial insurers were subject to a surcharge of 24% during the relevant period -- and still are surcharged 13% -- regardless of whether they offer community rating or open enrollment.[22] And the Blues do *not* pay the surcharges even for patients covered under large group contracts that are not community rated (J.A. 275).

In sum, not only do the surcharges not *regulate* any integral part of the relationship between insurer and policyholder, but they have no significant effect on that relationship.

c. The surcharge laws are not limited to entities in the insurance industry.

Finally, the surcharges do not "impose requirements only on insurers." *Metropolitan Life*, 471 U.S. at 743. The courts below unsurprisingly agreed that the surcharges are not limited to entities within the insurance industry. Pet. App.

---

[22] The Blues mistakenly claim (Br. 40) that "until April 1, 1992, the [NYPHRM] statute * * * offered the incentive to commercial insurers to avoid a portion of the differential if they instituted open enrollment." In fact, this incentive lapsed at the end of 1990 (J.A. 227 & Exh. G thereto); regardless, it was not in effect when the Omnibus Act imposed the 11% surcharge and respondents commenced this case.

A26, A79. These laws prescribe requirements for hospital charges, not insurance companies.

The surcharge laws set the rates that hospitals must charge patients; neither hospitals nor patients are part of the insurance industry. Although the criteria for the surcharges refer in some case to insurance companies, they also refer to self-insured funds, HMOs, and individuals with no insurance at all.

In addition, by claiming that the surcharges are in fact limited to entities within the insurance industry, petitioners ask this Court to broaden the savings clause to encompass not only the regulation of insurance but also the regulation of medical service providers such as HMOs. See, *e.g.*, HANYS Br. 41. That invitation ignores the fundamental differences between an HMO and an insurance company.[23] Both courts below recognized that, as a matter of law, HMOs are not engaged in "insurance," the regulation of which is saved from ERISA preemption.

Although petitioners try to characterize HMOs as "insurers" that create security against loss from illness or accident and distribute the attendant financial risk, the Blues correctly concede (Br. 42) that "the role that HMOs play with members" is not to insure against unforeseen risks, but to "provide health care services for a fixed fee." As a result, courts long have held that HMOs are not engaged in the business of insurance. See, *e.g.*, *O'Reilly* v. *Ceuleers*, 912 F.2d 1383, 1389 (11th Cir. 1990) (ERISA savings clause);

[23] The Blues (at 41) attempt to evade these differences by arguing that because HMOs may be subject to parts of the Insurance Law, they therefore are "persons" who are not "exempt" from "any law * * * which regulates insurance" (ERISA § 514(b)(2)(A)), and thus are "insurers" under the *Metropolitan Life* test. That circular reasoning begs the question whether the laws to which HMOs are subject in fact regulate *insurance* or merely regulate insurance companies and others. For the reasons explained in the text, HMOs do not in fact provide "insurance" and thus are not subject to laws that "regulate[] insurance."

Jordan v. *Group Health Ass'n*, 107 F.2d 239, 246 (D.C. Cir. 1939) (cited with approval in *Royal Drug*, 440 U.S. at 228). But see, *e.g.*, *Klamath-Lake Pharmaceutical Ass'n* v. *Klamath Medical Services Bureau*, 701 F.2d 1276, 1286-87 (9th Cir.), cert. denied, 464 U.S. 822 (1983) (McCarran-Ferguson Act). New York's regulatory scheme leads to the same conclusion, because the regulation of HMOs is plainly distinct from the regulation of insurance. Although the Public Health Law requires HMOs to comply with a few provisions of the insurance laws, HMOs need not be state-licensed insurers. Pet. App. A26-A27; N.Y. Ins. Law § 1109(a). Indeed, New York *forbids* HMOs to *call* themselves insurers. Pet. App. A27; N.Y. Pub. Health Law § 4411. Apparently, petitioners contend that the forbidden appellation may be applied to HMOs only for the purpose of saving broad state laws from preemption.

Petitioners insist that the 11% surcharge, at least, is limited to entities in the insurance industry because it is paid only by commercial insurance companies. N.Y. Br. 32; Blues Br. 33. But that is not true: under Section 348 of the Omnibus Act, the obligation to pay the 11% surcharge to the State does not fall upon commercial insurers. Rather, the *hospital* must add the surcharge to the bill of any patient covered by commercial insurance; it is the hospital, not the insurer, that risks civil penalties if the surcharge is not paid. See 1992 N.Y. Laws, ch. 41, § 104. New York deliberately chose *not* to impose the 11% surcharge on insurance companies.[24]

The surcharges plainly impose requirements and burdens on a broad array of persons and entities outside the insurance industry. Accordingly, the surcharges do not satisfy the third factor of the governing analysis.

[24] In vetoing a bill that would have required commercial insurers to pay the 11% surcharge to the State, Governor Cuomo expressly stated that "any effort to shift payment responsibility to commercial insurers [would] trigger retaliatory statutes in other states, resulting in an additional tax to New York-based commercial insurers." C.A. App. 1232.

B. This Court Should Not Alter Its ERISA Pre-emption Analysis In Order To Preserve New York's Attempted Regulation Of ERISA Plans.

Recognizing that this Court's prior cases compel the conclusion that the surcharge laws do not fall within the savings clause, petitioners ask this Court to change the rules. Petitioners suggest that ERISA's savings clause sweeps more broadly than the McCarran-Ferguson Act and that, despite past practice, this Court should now apply the tripartite McCarran-Ferguson analysis -- if at all -- more leniently in ERISA cases than in antitrust cases. Petitioners also suggest that the decision in *Fabe* somehow requires this Court to modify its analysis under the ERISA savings clause. These arguments are entirely insubstantial.

1. For one thing, in both *Metropolitan Life* and *Pilot Life* -- this Court's only prior decisions applying the savings clause -- the Court relied heavily on the same criteria used under McCarran-Ferguson in *Royal Drug* and *Pireno*. The Court neither relaxed the application of those factors nor suggested that its analysis differed from the McCarran-Ferguson analysis.

Moreover, the fact that the ERISA savings clause refers to "insurance" while the McCarran-Ferguson Act refers to the "business of insurance" does not suggest that the ERISA savings clause has a broader sweep. If anything, the "business of insurance" connotes a broader range than "insurance" alone, because the "business of insurance" includes activities beyond the mere "contract whereby, for a stipulated consideration, one party undertakes to compensate the other for loss on a specified subject by specified perils." BLACK'S LAW DICTIONARY 802 (6th ed. 1990).

Petitioners point to nothing in the statute or this Court's decisions to indicate that the word "insurance" in ERISA should be construed more broadly than the words "business of insurance" in the McCarran-Ferguson Act. On the contrary,

the Court long has equated the terms, noting that ERISA and the McCarran-Ferguson Act "utilize similar language to define what is left to the States." *Metropolitan Life*, 471 U.S. at 744 n.21.

2. The United States proceeds down another blind alley when it argues (Br. 21-22) that the savings clause must preserve not only laws that "regulate insurance," but also laws "purporting to regulate insurance companies," on the ground that the broader formulation appears in the deemer clause (ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B)). That argument fails for a simple reason: the savings clause does not contain the "purporting to regulate" language. See *Ingersoll-Rand*, 498 U.S. at 141 (rejecting attempt to transplant "purporting to regulate" language from the deemer clause into the preemption clause). In fact, this Court indicated in *FMC* that the scope of the deemer clause on its face is "broader * * * than that of the saving clause" (498 U.S. at 64). That interpretation, and not the government's, is in keeping with the broad preemption principle that Congress enacted with only narrow exceptions (*Pilot Life*, 481 U.S. at 46), and comports with this Court's policy to "give effect, if possible, to every clause and word of a statute." *Fabe*, 113 S. Ct. at 2210 n.6. Beyond this, whatever the surcharges may accomplish in fact, they unquestionably *purport* only to set hospital rates. Section 2807-c is headed "General hospital inpatient reimbursement," and appears in the Public Health Law within an Article governing "Hospitals."

3. *Fabe* does not provide petitioners with any more help. On the contrary, the Court in *Fabe* reaffirmed that the contractual "relationship between the insurance company and its policyholders" is the focal point of the business of insurance for McCarran-Ferguson purposes. 113 S. Ct. at 2208. It is true that the Court held that the McCarran-Ferguson Act reaches state regulation of the performance of contracts as well as of contractual terms. But the Court's focus remained on *the insurance contract itself*; the Court also held, after all, that a

state law directed exclusively at insurance companies did not fall within McCarran-Ferguson except insofar as it *directly* regulated the contractual relationship with policyholders. See *id.* at 2212.

Petitioners seize upon a dictum in *Fabe* to the effect that the "broad category of laws enacted 'for the purpose of regulating the business of insurance'" includes "laws that possess the 'end, intention or aim' of adjusting, managing or controlling the business of insurance," a category broader than the "business of insurance" alone. *Id.* at 2210.[25] Petitioners insist that the ERISA savings clause also encompasses laws with the "end, intention or aim" of regulating insurance. The savings clause cannot bear that freight, however; by its terms, the clause preserves only laws that "regulate[] insurance," not all laws enacted for "the purpose of regulating insurance." The scope of the ERISA savings clause depends on whether state laws actually *regulate* insurance.

Likewise, in reading the first clause of Section 2(b) of the McCarran-Ferguson Act more broadly than the antitrust exemption in the second clause, this Court relied on the presence of the word "purpose" in the first but not the second clause. *Id.* at 2209-10 & n.6. That reasoning on its face defeats the argument that the ERISA savings clause should receive the broader reading, because the word "purpose" is nowhere to be found in that clause.

In addition, the ERISA savings clause and the second clause in Section 2(b) of the McCarran-Ferguson Act perform similar functions. In each case, the provision at issue prevents certain regulatory choices of a State from being overridden by the preemptive force of a specific federal law. This Court's analysis in *Pilot Life* and *Metropolitan Life* reflects the correct judgment that the ERISA savings clause raises questions of

---

[25] In fact, the Court held that the statute at issue in *Fabe* did regulate the "business of insurance." *Ibid.*

statutory interpretation that are virtually indistinguishable from those in *Royal Drug* and *Pireno*. *Royal Drug* and *Pireno* turned on whether particular arrangements were part of the "business of insurance" and therefore exempt from the antitrust laws "to the extent * * * regulated by State law." 15 U.S.C. § 1012(b). Here, the inquiry is almost identical: the Court must determine whether a practice is "insurance," and whether a state law actually "regulates" it. 29 U.S.C. § 1144(b)(2)(A).

Most important, as we explained above, this Court's decision in *Fabe* confirms that even to come within the broad category of laws enacted "for the purpose of regulating insurance" -- a category broader than the actual regulation of insurance covered by ERISA's savings clause -- a state law must regulate the formation, terms, or performance of the contract between insurer and policyholder. The surcharge laws regulate none of these matters, and therefore do not fall within the coverage of the ERISA savings clause.

4. There are other important reasons for preserving this Court's long-standing analysis of the ERISA savings clause. To broaden the savings clause along the lines suggested by petitioners would obliterate the preemption principle that ERISA's sponsors considered the "crowning achievement" of the legislation. *Pilot Life*, 481 U.S. at 46 (quoting 120 Cong. Rec. 29,197 (1974) (statement of Rep. Dent)). As this Court has recognized, the sponsors' emphasis on "the breadth and importance of the preemption provisions" contrasts with their passing reference to the "narrow exceptions" to preemption. *Ibid.*

Under petitioners' view, however, states would be free to pass a broad assortment of laws interfering with the administration of ERISA plans so long as those laws could be said to have some impact on an ERISA plan's actions in the insurance marketplace -- or even had only the "stated purpose" (Blues Br. 32) of affecting the insurance market. Because plans and insurance companies both provide medical benefits, states could use putative "insurance regulation" to avoid

"through form" the substance of the preemption provision -- a result that "ERISA's authors clearly meant to preclude." *Alessi*, 451 U.S. at 525.

Following petitioners' open-ended rationale, virtually anything that a state legislature or insurance commissioner did to provide a commercial advantage for a favored insurance entity would be immune from preemption (and probably also immune from antitrust attack) -- no matter how disruptive of ERISA plans' operations and no matter how remote from regulation or taxation of insurance carriers themselves. The "narrow exceptions" would swallow the general rule. As with petitioners' proposal to narrow the preemption clause, such a sweeping change in the law should be left to Congress -- if it has any merit at all. It is the job of the legislature, not of the judiciary, to determine whether any "monumental changes * * * in the insurance marketplace" (Blues Br. 41) since the enactment of ERISA require adjustments in the terms of the Act.

C. The Deemer Clause Bars The Application Of The 13% Surcharge To Self-Insured Plans.

Even if this Court concludes that the 13% surcharge regulates insurance, that surcharge nevertheless is preempted insofar as it applies to self-insured ERISA plans. The deemer clause in Section 514(b)(2)(B) specifically "exempt[s] self-funded ERISA plans from state laws that 'regulat[e] insurance' within the meaning of the saving clause." *FMC*, 498 U.S. at 61. The deemer clause is as broad as the savings clause, if not broader; any law that is saved as an insurance regulation necessarily is preempted to the extent that it falls upon a self-funded plan. *Id.* at 64.

There is no dispute that, under Section 2807-c(1), self-insured plans may directly bear the burden of the 13% surcharge. The statute therefore is preempted to the extent it applies to those ERISA plans. No party seriously contests that conclusion of law. Petitioners (*e.g.*, HANYS Br. 37 n.32) and the United States (Br. 12 n.3) instead suggest that the

application of the 13% surcharge to self-funded plans is not before this Court. The record refutes that assertion.

To begin with, the complaints challenged the surcharge laws on behalf of self-insured plans. For example, Travelers sued as a fiduciary of the Sheridan Catheter Corporation's self-insured plan. J.A. 72-73; see also *id.* at 92-93 (other respondents suing in similar fiduciary capacities). Travelers' complaint expressly alleged that Section 2807-c(1)(b) "imposes a 13% surcharge for inpatient hospital care rendered to persons covered by * * * a self-insured ERISA plan such as the Sheridan Catheter Plan" (J.A. 81), and that "[i]n the case of a self-insured plan such as the Sheridan Catheter Plan, the 13% surcharge increases the overall cost to the plan of the claims administered by The Travelers" (*id.* at 82).

The district court, moreover, held that "those portions of the 13% [s]urcharge referring to self-insured plans could not possibly fall within the scope of the savings clause because * * * self-insured plans do not engage in the 'business of insurance' as a matter of law." Pet. App. A79. The district court later found that certain self-funded plans that refused to pay the surcharges were violating the court's stay of its order enjoining enforcement of the surcharges -- a violation possible only if that order encompassed the application of the surcharges to self-funded plans. (The district court's order to this effect, dated April 27, 1993, is attached as an appendix to the amicus curiae brief of the National Carriers' Conference Committee).

In fact, the Blues specifically appealed the district court's conclusion that "the savings clause could not apply to self-insured, as opposed to insured ERISA funds." Blues C.A. Br. 31; see *id.* at 39-40 (developing argument). Respondents devoted a section of their brief to respond to that argument (C.A. Br. 49-50), and the Second Circuit affirmed in full the injunction against enforcing the surcharges. Accordingly, even if this Court holds that the surcharges are saved from preemption when applied to insured plans, the Court should affirm the judgment of the court of appeals to the extent that it holds the surcharges preempted as applied to self-insured plans.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

Of Counsel:

STEPHEN M. SHAPIRO
KENNETH S. GELLER
ANDREW J. PINCUS
CHARLES ROTHFELD
DONALD M. FALK
Mayer, Brown & Platt
2000 Pennsylvania Ave., N.W.
Washington, D.C. 20006
(202) 463-2000

CRAIG P. MURPHY*
DARRELL M. JOSEPH
DANIEL W. DIENST
Windels, Marx, Davies & Ives
156 West 56th Street
New York, New York 10019
(212) 237-1000

**Counsel of Record*

JAMES M. MICHENER
The Travelers Insurance Company
Hartford, Connecticut 06183

ZOË BAIRD
Aetna Life Insurance Company; Aetna Health Plans of New York, Inc.
Hartford, Connecticut 06156

SETH A. JACOBS
The Travelers Health Network of New York, Inc.
Richardson, Texas 75082

THERESA L. SOROTA
The Health Insurance Association of America
Washington, D.C. 20036

JANE MEYER
Mutual of Omaha Insurance Company
Omaha, Nebraska 68175

PHILLIP E. STANO
American Council of Life Insurance
Washington, D.C. 20004

SUECAROL BUCKNER
The Union Labor Life Insurance Company
Washington, D.C. 20001

RAYMOND A. d'AMICO
Life Insurance Council of New York, Inc.
Albany, New York 12210

PAUL JOHNSTON
Professional Insurance Agents of New York, Inc. Trust
Glenmont, New York 12077

Dated: December 13, 1994